Increasing the Quality of Child Survival and Maternal Care Services in the Navoi Oblast of Uzbekistan

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Cooperative Agreement No.: FAO-A-00-99-00026-00

KPC MID-TERM SURVEY REPORT

March 2002

Project Location: Navoi Oblast, Uzbekistan

Project Duration: September 30, 1999 – September 29, 2003

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I. Executive Summary

In December 1999, Project HOPE initiated its child survival and maternal care project in the oblast of Navoi, Uzbekistan. HOPE is using a comprehensive approach of building the capacity of its partners and the community to reach the project goal of reducing maternal and child mortality and morbidity.

At project start-up, Uzbekistan had infant and child mortality rates of 50, per 1,000 and 62 per 1,000 live births, respectively, and the maternal mortality rate was estimated at 55 per 100,000 live births. The primary causes of deaths in children were ARIs, particularly pneumonias, perinatal causes, and diarrheal diseases. Immunization coverage rates were relatively high, but immunizable/infectious diseases, particularly hepatitis B (7% of children are chronic carriers) and measles were on the increase due to lack of funding for vaccines and supplies. Similarly to common childhood diseases (e.g., diarrheas and pneumonias), pregnancies and deliveries were not managed, using appropriate protocols. Mothers and babies were separated at births, often for 1-2 days, and while most women eventually breastfed, exclusive breastfeeding was virtually non-existent, increasing infants' risk for disease. Malnutrition in women and children was high: nearly one third of children were stunted in their growth and close to two-thirds of women and children suffered from anemia, with a potential long-term impact on their productivity and scholastic achievement. Women still had more children than they desired, and relied predominantly on the IUD.

HOPE is implementing this project in the oblast of Navoi, one of the three oblasts where the government is implementing the Health One program with support from the World Bank. Navoi has an ethnically diverse population of 769,000, living mainly on 10% of the land that is not desert. The oblast has the highest overall maternal mortality rate and the highest infant mortality rate due to diarrhea in the Republic.

The project interventions include maternal and newborn care, breastfeeding, child spacing, and the Integrated Management of Childhood Illness. Depending on the intervention, implementation has occurred at the oblast level and/or in two of Navoi's most population rayons, Kiziltepa and Karmana (Navoi City). Project strategies have included (1) the development of a core group of trainer-of-trainers at the oblast and rayon level in training skills and state-of-the art technical knowledge and skills; (2) the development of an environment that supports quality in health service delivery and health promotion and disease prevention and fosters problem-solving skills and initiative in HOPE's partners and health providers; and (3) the empowerment of the community through increased knowledge and skills to manage health at the household level. The project works in close coordination and collaboration with the central, oblast, and rayon Ministry of Health and its national research Institutes (Institute of Pediatrics, Center for Reproductive Health, National Institute of OB/GYN), local donors and contractors (USAID/Uzbekistan, Zdrav Plus – managed by Abt Associates, WHO, UNICEF, World Bank, and Medical Universities in Samarkand and Bukhara. Results the project expects to achieve by project end include:

- Competent providers that follow accepted protocols (e.g., IMCI, Safe Motherhood, reproductive health), use problem-solving skills, and are more sensitive to client needs;
- Improvement in the management of women from pregnancy through the post-partum period;
- Better breast-feeding practices through the establishment of "baby-friendly" maternity hospitals, lactation counseling, and breast-feeding support groups;
- Increased use of a variety of contraceptive methods and decreased unmet demand;
- Improved management of the ill and well child at the health facility level;
- A population that better capable to manage maternal and child health at the household level through disease prevention, management of basic illnesses, and appropriate care- seeking
- Model approaches that can be scaled-up by the MOH in the rest of the oblast and throughout the country; and
- Strengthened local groups and NGOs working in health.

While the project lost valuable time early on due to changes in local leadership, an external, participatory midterm evaluation (separate report) has provided qualitative information about substantial progress made by the project to date in a number of key areas and the strong acceptance and participation of HOPE's partners in the project activities.

In addition, in February/March 2002, the project also conducted observations of provider practices and surveys of clients in its two pilot rayons, Kiziltepa and Karmana to provide quantitative information that will give the reader an indication of changes under way in the pilot rayons. Where available, midterm survey findings are compared to the project baseline information which sampled from the entire oblast.

II. Methodology

Data were collected using two methods: observations of providers and interviews of clients and providers in the two target pilot rayons: Kiziltepa and Navoi (Navoi City included).

1. IMCI for health providers

A total of 36 health providers were observed[1]. The number of providers was determined in the following way:
Four IMCI provider training courses have been conducted since September 2001. Trainees from the first three trainings sessions were selected, since they had some time to practice.
The following were excluded:

- Trainees who do not practice in the 2 pilot rayons (i.e. Kiziltepa and Navoi) and Navoi City
- Trainees from in-patient hospitals
- Trainees who are policy makers (i.c. from MOH)
- Trainees who no longer practice medicine or have moved away from the area

A total of 36 providers remained of whom 100% were observed.

2. IMCI for Caretakers

A total of 152 interviews were conducted. These interviews consisted of approximately 50% exit interviews and 50% interviews at the caretaker's location. For the home-interview, caretakers were selected randomly from the health facility registration journal from those families whose children received treatment within the last 1-5 days.

3. IMCI for Health Facilities

27 IMCI-health facilities (i.e. where trained IMCI doctors work) were surveyed.

4. Reproductive Health for Health Providers

A total of 59 trained providers (out of 72 trained providers in the 2 pilot rayons) were interviewed at the health facility. This group was interviewed based on provider availability.

5. Reproductive Health for Women

A total of 393 women were randomly selected from the total group of women who gave birth in the two "baby-friendly" maternities starting in March 2001 (an equivalent of approximately 10% of those who delivered in those maternities during the last year); 309 interviews were actually conducted per availability.

[1] 45 questionnaires were completed as a number of providers were observed more than once (while accepting different patients). These additional 9 questionnaires were later randomly excluded from the analysis.

6. Breastfeeding for Mothers

This group consisted of the same 393 women randomly selected for the reproductive health survey; 305 interviews where actually conducted per availability. Women whose children had died were not included in this survey (a total of 4).

Survey questionnaires were prepared in English and then translated into Uzbek. The questions were taken and adapted from the KPC 2000+ and BASICS tools with input from HOPE HQ. The questionnaires also included additional program with specific questions. All questionnaires were discussed with the local team in Navoi with input from HOPE HQ.

The survey team consisted of HOPE personnel MOH, RH/BF/IMCI trainers and past RH/BF/IMCI trainees from the Central Rayon Hospital (CRH) of both Navoi and Kiziltepa rayons. The surveyors received training and conducted role-play prior to conducting the actual survey. Each survey had a HOPE supervisor. At the end of each day, the supervisor reviewed the surveys and discussed the findings with the project director.

All data were analyzed and entered into Epi-Info version 6.04d; diagrams and charts were made on MS Excel 2000. The findings were compared with the baseline KPC results obtained in May 2000 and with a post-partum care study carried out in August 2000. The current survey of March 2002, only included the two priority rayons (Kiziltepa and Navoi) that the project is currently targeting. The baseline of 2000 includes the entire Navoi oblast. This should be taken into account when comparing data from both surveys.

III. Key Findings

Reproductive Health

- Substantially improved knowledge of providers about most contraceptive methods.
- 80.7% of the women take part in the decision making on which type of contraceptive method to use;
- 88.3%-94.5% of the women are familiar with LAM but only 40.8% know about the 3 criteria;
- 74.9% of the women would like to have their next child more than 2 years from now
- Counseling rate on family planning is over 90%;
- Of the women who delivered in "baby-friendly" maternities within the last year) 93.8% use a method of contraception

Breastfeeding Mean age infant about 6 months

- Prevalence of the Kangaroo method (immediate newborn-mothers skin contact) was 92.4%; rooming-in within first hour was 91.4%
- 95% of newborns were breastfed within 8 hours of birth
- Prevalence of breastfeeding in mothers we had delivered in a baby-friendly maternity was 99.7%
- 97.7% of the mothers gave colostrum to the new born baby
- Exclusive breastfeeding for infants under 6 month is 41.6%

IMCI

- Danger signs assessment was completed in 91.0% of the cases observed
- Nutritional assessment was done in 80.6% of the cases, and counseling – 88.9%
- 54.7% of the caretakers know that tea has a negative effect on iron absorption
- In case of a diarrhea episode 47.7% of the caretakers would increase breastfeeding, 61.3% would increase fluid offering and 24.4% would increase solids/semi solids.

IV. Findings, Analysis & Conclusions

Reproductive Health

At the baselins (spring of 2000) the knowledge of midwives and obstetricians in the Navoi Oblast was poor. Only 36.1% of providers had received training in family planning, 43.0% knew the side affects of IUDs, 40.9% were able to list STI symptoms, and 60.1% had knowledge about HIV transmission.

In addition, counseling provided to patients was poor: the health providers decided which contraceptive method a client should use, providers did not take the medical conditions of the women into account. As a result, the IUD was the main method of contraception used by the population (86.9%-KPC 5/2000).

Reproductive Health for Health Providers

Trained providers demonstrated a 25-30% higher knowledge than providers at baseline.

- **Lactational Amenorreha Method (LAM) -** Knowledge of effectiveness of LAM was 66.1%, whereas the knowledge of the 3 criteria was 64.4%, and 50.9% of the respondents provided a correct answer to both questions.

- **COC Pill -** Knowledge of continuous use of this method was 81.4%; knowledge of at least five benefits was 86.4%; knowledge of effectiveness - 86.4%.

- **Injection** - Correct responses and good correlation were found regarding general knowledge (83.1%) and method effectiveness (81.0%).

- **Progesterone only Pills -** Correct responses and good correlation were found regarding general knowledge (84.7%) and method effectiveness (86.4%).

- **Sterilization** - General knowledge - 83.1%.

- **STI** - Excellent knowledge of AIDS transmission (94.9%) and of STI protection methods (91.5%).

- **Barrier Method -** Good knowledge of effectiveness (83.1%).

- **Calendar Method -** General knowledge averages at 81.4% for both questions with a correlation of 69.49% for both questions.

- **Emergency Methods** - Poor knowledge was observed in both questions (49.2% and 50.8% respectively); only 33.9% answered both questions correctly.

- **IUD** - General knowledge of both questions averages at 63.6% with a correlation of only 42.4% for the correct answer of both questions.

Analysis & Conclusions

Health providers have substantially increased their knowledge on the usage, effectiveness and benefits of different contraceptive methods, however there is still room for improvement, especially regarding LAM.

With respect to the IUD, there has been some progress and the knowledge of health providers is improving. As this is the most widely used method in the region, HOPE must emphasize correct use during the reproductive health trainings. Research does not agree on different issues, a fact that makes it very difficult to provide specific guidelines (and that may also explain the findings). Another element to consider is the possibility that the IUD questions were confusing and do not necessarily indicate the knowledge of health providers.

Interesting additional findings were obtained in focus groups conducted on March 22nd: The health providers agreed that most of the women they treat use LAM during the first 6 months after delivery, and only then (after the first 6 months) IUD is inserted. However, there are situations in which IUDs are inserted earlier:

- If the woman's menstrual cycle begins sooner (6-8 weeks after delivery), and
- If the woman is not certain about the effectiveness of LAM and trusts the IUD more.

An additional explanation for providers still inserting IUDs 6 days after delivery is the strong MOH child-spacing policy for the 8-10 years prior to 2001, which urged health providers to insert IUDs soon after delivery. Thus, many providers have not yet changed practices.

In conclusion, health providers have gained additional knowledge and appear to be in the process of changing their behavior, though additional time will be required to eliminate previous practices. Thus, additional training in reproductive health and focused trainings on specific contraceptive methods are planned to increase the knowledge and understanding of health providers.

Reproductive Health for Women

Women appear to receive more information on STIs and contraception than at baseline. In May 2000, only 34.7% and 41.7%[2] of women were counseled postnatal by a health provider on STIs and contraception, respectively. Of the women delivering in baby-friendly maternities, 90.5% reported to have received STI counseling and 95.8% - contraception counseling.

Information

Health facilities are the main source of contraception information, the SVP being the major one (60.8%), followed by the Maternity house and women consultation polyclinics in second and third place (43.4% and 42.7% respectively). As a source of information about these topics, friends and relatives received a relatively low score of 15.2% (below the 28.8% for mass media). It appears that community activists do not play a major role in providing reproductive health information, as only 1.9% of the women consulted with activist.

Counseling

95.8% of the women said that the health provider discussed the issue of contraception with them, and 87.2% received explanation from the health provider regarding contraceptive methods.

Contraception

93.8% of the respondents are currently using a method of contraception; only 4.8%[3] would like to have another child within the next 2 years, with a majority of 74.9% planning to have a child more than 2 years from now.

As for changes observed in decision-making regarding the choice of contraceptive method, 80.7% of women took an active role in the decision (65.9% of the women decided independently and 14.8% reached a decision with their husband).

Women's knowledge of contraceptive methods has increased dramatically: 99.7% of the women were familiar with the IUD, 91.6% with the injection, and 90.9% with the pill (in August 2000, reported knowledge was 77.6%, 63.6% and 47.0% respectively). However, it appears that women are not well informed about other methods (especially vasectomy – 15.2% and emergency contraception – 4.9%, respectively).

88.3% of women are familiar with LAM and 94.5% know that exclusive breastfeeding can serve as a child spacing method, however only 40.8% of the latter knew the 3 criteria, of LAM, indicating that actual LAM practice is not very effective.

[2] In the DIP the percentages appeared once as above and once as 41.7% for STI and 34.7% for contraception. An additional 66.7% was found for contraception as well.
[3] The findings in KPC 5/2000 varied between 21% and 46%; a percentage of 30.4% was observed in the August 8/2000 report.

STI

A majority of women have a pretty good knowledge of STIs (probably from a combination of sources primarily health providers and mass media), but do not know how to protect themselves from these diseases. For example, 94.5% of the women have heard about AIDS (82.7% - KPC 5/2000), but when asked if they know how to protect themselves from STIs, 77.9% stated by having only one partner, 57.3% by abstaining, and 46.9% by using a condom (25.0%, 25.3% and 6.7% respectively, KPC 5/2000).

Analysis & Conclusions

Health providers continue to be the main source of information for women, and counseling by providers appear to be increasing. However, it is important to consider that when asked if a health provider gave counseling, women are likely to answer yes to not complicate matters for the health providers. The findings indicate that community activists do not serve as a major source of information. The project will reassess how to incorporate activist more effectively into reproductive health education.

93.8% of the women surveyed use a method of contraception, and only 4.8% of the respondents would like to have another child within the next two years. These two findings indicate that the health providers counsel women on the need to use contraception for child spacing and to control their fertility.

80.7% of the women participate in choosing a contraceptive, however, 17.0% of the women still have no say on this matter. It is therefore imperative to continue to emphasize with health provider the need to counsel the women on this issue and give them the opportunity to make the decision.

Though women's knowledge on contraceptive methods has increased, they still lack knowledge about some methods, such as emergency and surgical methods. Actual knowledge about LAM has also increased, but women's knowledge of the 3 LAM criteria is incomplete. This is due to both the lack of knowledge of health providers about LAM and, in some cases, to insufficient counseling.

During the focus sessions with providers conducted on March 22nd, the participants groups were asked what LAM means. Many answers were given, but only at a certain point, when one provider (from each group) mentioned the "3 criteria", did the others jump up and agree. This finding indicates that the LAM criteria do not receive enough emphasis in the training curriculum. In addition, the providers mentioned that the advantages of exclusive breastfeeding are known for nutrition, but much less for contraception.

When asked why LAM as a contraceptive method is not very popular with women, the providers answered that it is due to lack of knowledge that exclusive breastfeeding can serve as a contraceptive method. However, now that they have the knowledge and are familiar with the method they will inform the women and believe that in time the use of LAM will increase.

In conclusion, reproductive health trainings should further emphasize less known contraceptive methods and devote more attention to LAM and LAM criteria. Project HOPE will integrate LAM more fully into the "baby-friendly" hospital program[4].

[4] Project HOPE is exploring work with Linkages on this program.

STIs

Women's knowledge about STIs has improved, however knowledge about prevention is still insufficient (especially use of condoms). It is essential that health providers, have good knowledge on this topic, provide women with more effective counseling.

In focus groups, health providers were asked for ideas to better disseminate information about condoms to the population. The need for counseling women about STI prevention was mentioned, as well as the following:

- Makhalla – during home visits and meetings with makhalla, STI should be discussed and couples should receive some condoms as samples.
- Mass media – announcements on TV might be effective
- Adolescence – provide teenagers with counseling at various gathering locations

Breastfeeding for Mothers

Prior to the project there were, no "baby-friendly" clinics in the target area. As part of the breastfeeding intervention, HOPE began to establish two "baby-friendly" maternities in the Central Rayon Hospitals of Vizillepa and Karmana in March 2001. These clinics received UNICEF certification in October 2001 and follow the "10 steps for successful breastfeeding".

First Skin Contact (Kangaroo Method)

The Kangaroo method is practiced in the “baby-friendly” maternities in 93.4% of the deliveries sampled: in 92.4% of the deliveries, the mother received the baby at once, and in an additional 1.0% - within 30 minutes.

Of those who received their newborn after more than 30 minutes, only 50% had a natural delivery.

Rooming-In

Rooming-in is also practiced frequently with 86.2% of the mothers receiving their babies immediately and 5.2% within 1 hour from birth. Only 5.2% of the new mothers received their babies after more than 4 hours, however only 31.3% of this group had a natural delivery.[5]

Breastfeeding

Prevalence of breastfeeding by women delivering in baby-friendly maternities is 99.7% (76.7%- KPC 5/2000). 95.0% of the mothers reported to have breastfed within 8 hours of birth (only 50% KPC 5/2000); 46.7% of those who breastfed after more than 8 hours had a C-section. 97.7% reported giving their baby colustrum (76% - KPC 5/2000).

96.1% of the surveyed mothers are currently breastfeeding. Of those no longer breastfeeding (3.9%),
91.7% of all mothers stopped breastfeeding during the first 6 months and 8.3% - after the first 6 months.
98.6% feed their babies on demand.

More than half (54.6%) of the breastfeeding mothers said they plan to breastfeed for 1 to 2 years, and 45.4% - for more than 2 years. No correlation to gender could be found.

[5] In August 2000 66.8% of the babies roomed-in with a mean time of placement with the mother of 26 hours.

Exclusive Breastfeeding

Exclusive breastfeeding in the "baby-friendly" maternities is gaining popularity, with a rate of 58.2% of infants less than 4 months and 41.6% for infants less than 6 months. These percentages are a considerable improvement from 2000, 4.2% of mothers practiced exclusive breastfeeding for the first 3 months (DHS) and 8.7% - for the first 4 months (KPC 5/2000).

Sources of Health Information

The main source of information for women are the health providers (96.3%), with family members lagging far behind (3.0%). 98.3% of new mothers received information about breastfeeding and childcare prior to delivery; 98.7% received counseling at the maternity after delivery; 97.0% received counseling during their first visit to the health facility after delivery.[6]

66.8% of mothers recall health provider informing them about the women support groups, however only 12.8% used these services.

Analysis & Conclusions

The breast feeding results for women delivering in "baby-friendly" maternities are very possible: Early skin contact, rooming-in, and breastfeeding are practiced on a regular basis, and mothers receive counseling from the health providers at most major points of contct with the health system. The rate of full breastfeeding as, well as exclusive breastfeeding has increased dramatically.

The findings regarding women support groups indicate the difficulties in introducing a new source of information, but do not necessarily indicate lack of usage: During the breastfeeding trainings of providers, women support groups are mentioned as a means to promote breastfeeding within the population and to help breastfeeding mothers. Thus, it may be possible that only women who had difficulties breastfeeding sought help (i.e., it is not expected that all women will have problems breastfeeding). Nevertheless, as women's groups are a very new trend in Uzbekistan, it is expected that dissemination about these groups and their use for providing information and counseling to new mothers will take some time.

[6] These findings are much higher than those observed in KPC 5/2000.

IMCI Health Provider Observation

Assessment

The provider observations indicated that an assessment of danger signs was completed in 91.0% of the cases observed (88.9% for convulsions and 91.7% each for not drinking, vomiting and drowsiness). 86.1% of the providers checked the child's vaccination status and completed the weight assessment, and 91.7% examined the child for malnutrition/anemia.

In 100.0% of the cases the health provider correctly assessed the need to provide antibiotics, and no inappropriate antibiotics were prescribed (as opposed to 38% of the diarrhea cases that receive antibiotics in May 2000).

In more than 80% of the cases, the health provider assessed the child's nutritional status (80.6% "assessed" the nutritional status and 86.1% "inquired" about the nutritional status.

Counseling of Caretakers

After the nutritional assessment, the health provider gave nutrition counseling in 88.9% of the cases (only 23% at the KPC 5/2000).

As for home care, the health providers explained the illness to the caretaker (86.1%) and provided further guidance for treatment at home; i.e., when/how to give fluids (83.3%), food (97.2%) and medication (44.4%).

Though in only 50.0% of the cases, the health provider informed the caretaker of danger signs, in 94.4% of the cases the provider explained when the caretaker should seek health care and return immediately to the health facility. Also, in 91.7% of the cases the health provider scheduled a follow up visit. In (51.4%) only about half of the cases did the provider fully complete the individual health card according to the IMCI guidelines.

Analysis & Conclusions

These assessment findings indicate a substantial improvement in health provider practices. In most cases, the doctors followed the IMCI protocol and properly assessed the sick child.

Counseling of caretakers also increased dramatically and in general has reached a satisfactory level that needs to be maintained. The recent findings are notably higher than those observed at baseline in May 2000 in which only 37.6% of caretakers received some advice on nutrition, 25-40% were counseled on the importance of giving fluids and food at home, 13% received instruction on danger signs for immediate return to the health facility, and 51.4% were told when to come for a follow-up visit.

Some of the current findings need more explanation, particularly the one about counseling in danger signs. This finding might be due to the IMCI guidelines: Even though health providers receive training in danger signs, the protocols do not emphasize the need to consel the caretakers on these danger signs. Thus, in future IMCI trainings, the IMCI trainers should emphasize the need to educate the caretakers about danger signs.

As for lack of counseling on how to use a medication, this finding may be due to the fact if no medicine is prescribed, counseling about it is not necessary. Since antibiotics were prescribed in only 2.8% of the cases (and findings for other oral medications could not be generated), it is difficult to assess whether counseling was adequate.[7]

The issue of completing the medical individual cards is a problematic one as a reason for not completing the cards is due to the fact that the IMCI record form is not available. This issue of who should provide these forms is currently under discussion on the national level. Project HOPE provides the health providers with about two dozen copies after the IMCI training as well as during monitoring, but obviously this is not sufficient.

In summary, home care consultation is good, but trainings should provide additional emphasis on treatment at home and focus on informing the caretakers about danger signs.

[7] The findings from the caretaker survey indicate that counseling about how to take medications may be adequate since 82.4% of the caretakers did know how to correctly administer the medication.

IMCI for Caretakers

Caretaker Behavior

Caretakers tend to seek health care on the second day of the illness (50.0% in response general to general signs and 55.6% specifically in the case of cough or difficult/fast breathing).[8]

82.4% of the caretakers know the correct dosage and frequency of the prescribed medication (only 30.9% in KPC 5/2000), a finding that indicates good counseling by the health provider.

An overwhelming majority of the caretakers noted that the health provider inquired about (97.3%) and counseled (95.8%) them on the child's nutritional status. Most probably because of that 54.7% of mothers know that tea has a bad effect on iron absorption.

As for feeding during a diarrhea episode, 47.7% of the caretakers said they would increase breastfeeding and 61.3% would increase fluids. However, in addition, 14.3% still stated that they would reduce liquids and 9.2% did not know what to do. In addition, only 24.4% of respondents would offer more food, with a majority of 47.3% offering less food than usual.

Caretakers are familiar with and look out for danger signs indicating the need to return immediately to the health facility, however the knowledge remains limited. The most commonly known danger sign is high fever (86.2%), with the other signs lagging behind (sickness is getting worse – 59.2%; fast or difficult breathing – 43.4%; not breastfeeding or drinking – 37.5%; blood in stool – 23.0%). Only 4.6% of the caretakers could list all five danger signs, 16.4% - four signs, and 29.6% - three signs.

79.7% of the caretakers knew when to come for a follow-up visit compared to 63.5% in baseline.

Analysis & Conclusions

Within a short time, caretaker's knowledge has improved, though additional education is required for more substantial behavioral change and improved practices. Knowledge of the negative effect tea has on iron absorption and the increase in feeding during diarrhea episodes indicate improvements (in May 2000 only 30.3% offered more fluids and only 4.7% offered more food), though more efforts are needed to improve these percentages. A major obstacle to improved feeding practices are the post guidelines to not feed the child for 6 hours after a diarrhea episode[9]. It is expected that in time, with continued training of health providers the dissemination of the Mother Reminder Materials and parent education, the behavior of caretakers will continue to change.

[8] According to the KPC survey conducted in May 2000 64.8% of the mothers sought care on the first day of an episode of a cough or fast breathing. We find this result difficult to explain in light of the current results and after treatment by IMCI health providers.

[9] This fact is supported by findings from the formative research report (December 2001) in which 59% of the caretakers said that during a diarrhea episode they would feed their children less than usual, 21% would stop feeding them altogether, and only 2% would feed them more than usual.

The improvements in the knowledge of danger signs show the difficulty in remembering and memorizing several pieces of information simultaneously. Hopefully the Mother Reminder Materials (and additional education and counseling) will solve this problem. Further emphasis in IMCI trainings on danger signs and immediate return to the health facility, as well as informative posters in the health facilities should support behavior change.

IMCI Health Facility

Facility and Equipment

A majority of the facilities had a functional weighing scale and timer (92.6% and 85.2%, respectively), a working refrigerator (88.9%) and an IMCI protocol folder. However, many facilities did not have a separate corner for treatment with oral rehydration fluids (66.7%), education materials or IMCI record forms (29.6% and 25.9% respectively).

Required vaccinations

Most vaccines were available (between 88.9-96.3%), with the exception of vaccines for Flu and Mumps, which have not been available for the last 5-6 years.

IMCI drugs

Drug availability ranged widely from 0.0% for Gentian violet and 3.7% for Chloromfinicol to 81.5% for Paracetamol and 92.6% for ORS.

Analysis & Conclusions

The lack of separate treatment corners for ORT is due to limited space in the health facilities. The materials and IMCI record forms further emphasizes the difficulties of IMCI implementation nationwide with nobody taking responsibility for providing these materials. At the national level, Project HOPE is making an effort to improve this situation with the IMCI steering committee; and at the regional level, HOPE is urging the health facilities to produce their own education posters. It is also expected that the Mother Reminder Materials will be available at the health facilities.

The drug situation is well known, and Project HOPE is making an effort to provide IMCI drugs when possible. Two drug shipments received in 2001 (and two additional ones scheduled for April and August 2002) should improve the situation somewhat.

V. Action Plan

Reproductive Health

- Integrate LAM into the education content at "baby-friendly" maternities and breastfeeding counseling to increase the effective and correct use of LAM;
- Translate materials related to emergency contraception and integrate them into the reproductive health trainings;
- Increase the knowledge of health providers on women's physiology and natural family planning methods;
- Underline the need to counsel women and give them the opportunity to make their choice of contraceptive;
- Stress the need to better inform the women on prevention of contraceptive; STIs and HIV/AIDS; and RH
- Continue training and supervision to improve the practices of providers. Trainings planned for 2002 include:
    - STIs
    - Antenatal Care / Safe Motherhood
    - Emergency Contraception
    - LAM (explore support from Linkages)
    - Female Sterilization (minilaporotomy)

Breastfeeding

- Integrate with training on Antenatal Care / Safe Motherhood and LAM to further increase the knowledge of health providers;
- Establish two additional “baby-friendly” maternities in Navoi oblast;
- Conduct monitoring of the “baby-friendly” maternities every 6 months, with MOH supervisors;
- Initiate community activities to improve the knowledge and practice of exclusive breastfeeding; and
- Support groups to Makhalla committee and promote their use.

IMCI

- Continue to emphasize the importance of counseling the caretakers on treatment at home, with a focus on providing information about danger signs;
- Produce and distribute Mother Reminder Materials and educate caretakers on danger signs and timely care seeking;
- Encourage health providers to produce their own education materials; and
- Promote facility-and community-IMCI issues at the national level

Appendix 1: Survey Results

Reproductive Health for Health Providers

Health providers surveyed	**59**
▪ Medical doctors	36
▪ Midwives	17
▪ Nurses	6
Lactational Amenorreha	
Knowledge of effectiveness (A7)	66.1%
Knowledge of 3 criteria (A9)	64.4%
Answered both questions correctly	50.9%
COC Pill	
Knowledge of continuous usage duration (A10)	81.4%
Knowledge of at least 5 benefits (A11)	86.4%
Knowledge of effectiveness (A12)	86.4%
Answered 3 questions correctly	62.7%
Injection	
General knowledge (A15)	83.1%
Knowledge of effectiveness (A18)	81.0%
Answered both questions correctly	72.4%
Progesterone only Pills	
Knowledge when to take the pill (A19)	84.7%
General knowledge (A20)	86.4%
Answered both questions correctly	71.8%
Sterilization	
General knowledge (A23)	83.1%
STI	
Knowledge of AIDS transmission (A26)	94.9%
Knowledge of protection method (A28)	91.5%
Answered both questions correctly	88.14%

Barrier Method	
Knowledge of effectiveness (A30)	83.1%
Calendar Method	
General knowledge (A31)	76.3%
General knowledge (A32)	86.4%
Answered both questions correctly	69.5%
Emergency Method	
General knowledge (A33)	49.2%
General knowledge (A34)	50.8%
Answered both questions correctly	33.9%
IUD	
General knowledge (A35)	62.7%
General knowledge (A36)	64.4%
Answered both questions correctly	42.4%

Reproductive Health for Women

Surveyed group	
Total number of women	309
Mean age	25.3
Source of contraception information	
SVP	60.8%
SVA	15.2%
SUB	3.2%
CRH	4.2%
CRP	9.1%
Women consultation polyclinic	42.7%
Maternity house	43.4%
Community activists	1.9%
Friends / relatives	15.2%
Mass media	28.8%
Pharmacy	1.6%
Don't know	0.3%
Health provider discussed the issue of family planning / contraception	95.8%
Health provider explained the different contraception methods	87.2%
Contraception method decision maker	
Health provider	17.0%
Woman	65.9%
Husband	2.3%
Woman and husband together	14.8%
Familiarity with contraception methods	
Injections	91.6%
Pill	90.9%
Barrier methods (diaphragm, condom, foam/gel)	55.3%
IUD	99.7%
Tubal ligation	69.3%
Vasectomy	15.2%
LAM	88.3%
Withdrawal	46.0%
Calendar method	42.7%
Emergency contraception	4.9%

Abstinence	51.5%
Child spacing	
Within 1 year	0.5%
Within 2 year	4.3%
In more than 2 years from now	74.9%
Unsure when	20.3%
Usage of contraception method to avoid pregnancy	93.8%
Exclusive breastfeeding / LAM for contraception	
Familiarity with method	94.5%
Knowledge of the 3 conditions (of those who were familiar with the method)	40.8%
Received STI information from health provider	90.5%
Familiarity with diseases	
AIDS	94.5%
Syphilis	74.3%
Gonorrhea	49.2%
Trichomoniasis	17.3%
Clamidiyas	4.2%
Other (generally Candidosis)	10.4%
Knowledge how to protect oneself from STI	
Use condom	46.9%
Abstinence	57.3%
Have only one partner	77.9%

Breastfeeding for Mothers

Surveyed group	
Total number of women	304
Mean age	25.3
First skin contact (Kangaroo method)	
At once	92.4%
Within 30 minutes after delivery	1.0%
More than 30 minutes after delivery	6.6%
Note: out of those who received their child after more than 30 minutes only 50% had a natural delivery.	
Rooming-in	
At once	86.2%
Within 1 hour	5.2%
Within 1-4 hours	3.3%
After more than 4 hours	5.2%
Note: out of those who did not room-in only 31.3% had a natural delivery.	
Prevalence of breastfeeding	99.7%
First breastfeeding	
Within 1 hour	89.1%
Between 1-8 hours	5.9%
After more than 8 hours	4.9%
Note: 46.7% of those who breastfed after more than 8 hours had a C-section delivery.	
Gave colostrum	97.7%
Currently breastfeeding	96.1%
Exclusive breastfeeding[10]	
Infants under 4 months old	58.2%
Infants under 6 months old	41.6%
Breastfeed on demand	98.6%

[10] This finding is based on results from 296 questionnaires (due to data entry errors).

Planned breastfeeding period	
0-6 months	0.0%
6-12 months	0.0%
1-2 years	54.6%
Over 2 years	45.4%
Note: no correlation to gender could be found.	
Received breastfeeding and childcare information prior to delivery	**98.3%**
Source of information:	
Family members	3.0%
Friends	0.7%
Health providers	96.3%
Women support groups	0.0%
Information was usually given at:	
Women consultation/polyclinic	34.9%
Antenatal department	61.3%
Home	3.8%
Post natal child care and breastfeeding consultation at the health facility	
Received consultation at the facility after delivery	98.7%
Received consultation during the first visit to the facility after delivery	97.0%
Information about women support groups	
Informed by the health provider about the women support groups	66.8%
Used the women support group services	19.2%

IMCI for Health Providers

Number of health providers observed	36
Danger signs assessment	
Not drinking	91.7%
Vomits everything	91.7%
Convulsions	88.9%
Lethargic or difficult to wake	91.7%
Module classification	
Cough and/or difficult/fast breathing	72.2%
Diarrhea	8.3%
High fever	27.8%
Pain/trouble swallowing	16.7%
Ear problems	11.1%
Assessment	
Malnourished and/or anemic	91.7%
Vaccination status	86.1%
Weight assessment according to chart	86.1%
Other	22.2%
Cases in which the child should receive antibiotics	2
Prescribed antibiotics when needed	1
Prescribed antibiotics when not needed	0
Should give first dosage of antibiotics before hospitalization	1
Asked about the child's nutrition	86.1%
Assessed the child's nutritional status	80.6%
Gave nutrition consultation	88.9%
Sickness consultation and guidelines for treatment at home	
Explanation of sickness	86.1%
When/how to give fluids	83.3%
When/how to give food	97.2%
When/how to give medication	44.4%
Danger signs	50.0%
When to return immediately to the health facility	94.4%
Scheduled follow up visit	91.7%
Completed individual card	51.4%

IMCI for Caretakers

Number of caretakers interviewed	152
Type of caretaker	
Mother	96.6%
Father	0.0%
Grandmother	1.3%
Grandfather	0.0%
Mother-in-law	2.0%
Father-in-law	0.0%
Other	0.0%
Reason for visit at the health facility	
Diarrhea	3.3%
Blood in stool	0.0%
Cough	40.1%
Difficult or fast breathing	6.6%
Fever	17.1%
Convulsions	2.0%
Ear problems	4.6%
Pain in the throat	5.9%
Pre-scheduled appointment / health day	44.7%
Duration of sickness before seeking health care	
One day (or same day)	26.8%
Two days	50.0%
Three days or more	23.2%
Duration of sickness before seeking health care (for cough or difficult/fast breathing	
One day (or same day)	17.5%
Two days	55.6%
Three days or more	27.0%

Knowledge of correct medicine dosage and frequency	82.4%
Doctor inquired about child nutrition	97.3%
Doctor consulted caretaker about child nutrition	95.8%
Knowledge of effect tea has on iron absorption	
Good	9.3%
Bad	54.7%
No effect	4.0%
Don't know	32.0%
Breastfeeding during diarrhea episode	
Less	13.3%
Same	28.9%
More	47.4%
Child doesn't breastfeed	0.0%
Don't know	10.4%
Fluid offering during diarrhea episode	
Less	15.3%
Same	15.3%
More	61.3%
Nothing to drink	0.0%
Don't know	8.0%
Food offering during diarrhea episode	
Less	47.3%
Same	18.3%
More	24.4%
Nothing to eat	3.1%
Don't know	6.9%
Knowledge of danger signs for immediate return to the health facility	
Don't know	3.3%
Sickness is getting worse	59.2%
Not breastfeeding or drinking	37.5%
Blood in stool	23.0%
High fever / fever is not going down	86.2%
Fast or difficult breathing	43.4%

Danger signs for immediate return to the health facility – quality of knowledge	
Don't know	3.3%
Know 1 sign	20.4%
Know 2 signs	25.7%
Know 3 signs	29.6%
Know 4 signs	16.4%
Know all 5 signs	4.6%
Scheduled next visit	79.7%

IMCI for Health Facility

Number of health facilities	27
Type of health facility	
CRH	3.7%
CR Child Polyclinic	14.8%
SUB	3.7%
SVP	59.3%
SVA	7.4%
City health facility	11.1%
Region	
Navoi Rayon	29.6%
Kiziltepa Rayon	51.9%
Navoi City	18.5%
Functional weighing scale	92.6%
Functional timer	85.2%
IIMCI protocol folder	88.9%
IMCI record form	25.9%
Reminder materials	29.6%
Separate corner for oral rehydration treatment	66.7%
Working refrigerator	88.9%

Required vaccinations	
TB	88.9%
DPT	88.9%
Hepatitis B	96.3%
Flu	0.0%
OPV	88.9%
Measles	88.9%
Mumps	0.0%
IMCI drugs	
ORS	92.6%
Amoxicilin	29.6%
Penicillin	74.1%
Erytromicin	59.3%
Gentamicin	66.7%
Paracetamol	81.5%
Tetracycline eye ointment	70.4%
Gentian violet	0.0%
Vitamin A	37.0%
Iron supplements	70.4%
Bicillyn 1	63.0%
Chloromfinicol	3.7%
Nose-Gastralprobe	44.4%
Sterile syringe	92.6%
Gauze pad	88.9%
IV kit	88.9%
IV solutions for acute dehydration	37.0%

Appendix 2: Survey Questionnaires

Questionnaires

Below are the questionnaires as they appear in Epi-Info.

BREASTFEEDING QUESTIONNAIRE FOR MOTHERS
MOTHERS WHO DELIVERED AT "BABY-FRIENDLY" CLINICS FROM FEBRUARY 2001
MIDTERM EVALUATION APRIL 2002
PROJECT HOPE/CS/NAVOI

Date <dd/mm/yy> {Rec}ord {Num}ber <idnum>

IDENTIFICATION

{A1} Region #
1 NAVOI RAYON
2 KIZILTEPA RAYON

{A2} Which health facility do you usually go to? TYPE OF HF: ##

{A3} Age of mother ##

{A4} Child's date of birth <dd/mm/yy>

{A5} Child's gender: #
1 Female
2 Male

{A6} What type of delivery did you have? #
1 NATURAL
2 C-SECTION
3 OBSTERICAL FORCEPS
4 VACCUM EXTRACTION
5 PROTRACTED LABOR (CHILD SUFFERED FROM TRAUMA)
6 PREMATURE BIRTH

{A7} When did you first have skin contact with your baby? #
1 AT ONCE
2 WITHIN 30 MINUTES AFTER DELIVERY
3 MORE THAN 30 MINUTES AFTER DELIVERY

{A8} # After you were transferred to the post-partum room (and after gained conciousness from operation), when did you first receive your baby?
1 AT ONCE
2 WITHIN 1 HOUR
3 WITHIN 1-4 HOURS
4 AFTER MORE THAN 4 HOURS

{A9} Did you ever breastfeed your child? #
1 YES
2 NO SKIP TO QUESTION A21

{A10} How long after birth did you breastfeed for the first time? #
1 WITHIN ONE HOUR
2 WITHING 1-8 HOURS
3 AFTER MORE THAN 8 HOURS

{A11} # Within three days after delivery, before your breastmilk began flowing regularly, did you feed your baby the liquid that came from your breasts?
1 YES
2 NO
3 DON'T KNOW / DON'T REMEMBER

{A12} Are you currently breastfeeding your baby? #
1 YES
2 NO SKIP TO QUESTION A20

13 In the last 24 hours, have you given your child any of the following:
{A13A} BOILED WATER <Y>
{A13B} TEA <Y>
{A13C} JUICE <Y>
{A13D} OTHER TYPE OF MILK <Y>
{A13E} INFANT FORMULA <Y>
{A13F} PUREE (FRUIT AND VEGETABLES) <Y>
{A13G} FOOD FROM THE FAMILY TABLE <Y>
{A13H} Other <Y>
Please specify:

14 Have you ever given your child any of the following:
{A14A} BOILED WATER <Y>
{A14B} TEA <Y>
{A14C} JUICE <Y>
{A14D} OTHER TYPE OF MILK <Y>
{A14E} INFANT FORMULA <Y>
{A14F} PUREE (FRUIT AND VEGETABLES) <Y>
{A14G} FOOD FROM THE FAMILY TABLE <Y>
{A14H} Other <Y>
Please specify:

{A15} How often do you breastfeed? #
1 ON DEMAND
2 EVERY 3-4 HOURS
3 SOMETIMES (2-3/24 HOURS)

{A16} # Do you know what to do if your breasts are full of milk and your baby is asleep?
1 WAKE UP THE BABY AND TRY TO BREASTFEED
2 STRAIN THE BREAST
3 DON'T KNOW

{A17} When you feed liquids other than breastmilk, what do you use? #
1 BOTTLE WITH NIPPLES
2 SPOON AND CUP
3 OTHERS
4 ONLY GIVES BREASTMILK NOW

{A18} Do you give your baby a rubber nipple to suck on? <Y>

{A19} Until what age do you plan to breastfeed your child? #
1 0-6 MONTHS
2 6-12 MONTHS
3 1-2 YEARS
4 OVER 2 YEARS

{A20} For how long did you breastfeed your child (IN MONTHS)? ##
(ENTER 99 IF MOTHER DOESN'T REMEMBER)

{A21} # Before the delivery, did you receive any information about breastfeeding and child care?
1 YES
2 NO
3 DON'T REMEMBER

{A21A} If YES from who? #
1 FAMILY
2 FRIENDS
3 HEALTH PROVIDERS
4 WOMEN SUPPORT GROUPS

{A21B} Where? #
1 WOMEN COUNCULTATION/POLYCLINIC
2 ANTENATAL DEPARTMENT
3 HOME

{A22} <Y> During your stay in the health facility when your child was born, did you receive any help from the health providers on child care and breastfeeding?

{A23} <Y> During your first visit to the health facility after your child was born, did you receive sufficient breastfeeding counseling or advise?

{A24} <Y> Did the health provider inform you of the counseling services offered by the Women Support Groups?

{A24A} Have you ever used these services? <Y>

{A25} Did the health provider inform you of the Hot Line services? <Y>

{A25A} Have you ever used this service? <Y>

REPRODUCTIVE HEALTH QUESTIONNAIRE FOR WOMEN
MIDTERM EVALUATION APRIL 2002
PROJECT HOPE/CS/NAVOI

Date <dd/mm/yy> {Rec}ord {Num}ber <idnum>

IDENTIFICATION

{A1} Region #
1 NAVOI RAYON
2 KIZILTEPA RAYON

{A2} Which health facility do you usually go to? TYPE OF HF: ##

{A3} Age of woman ##

FAMILY PLANNING AND CONTRACEPTION

{A4} How many pregnancies have you had? #

{A5} How many children do you have? #

6 Where do you obtain information about contraception?
{A6A} SVP <Y>
{A6B} SVA <Y>
{A6C} SUB <Y>
{A6D} CRH <Y>
{A6E} CRP <Y>
{A6F} WOMEN CONSULTATION POLYCLINIC <Y>
{A6G} MATERNITY HOUSE <Y>
{A6H} COMMUNITY ACTIVISTS <Y>
{A6I} FRIENDS/RELATIVES <Y>
{A6J} MASS MEDIA <Y>
{A6K} PHARMACY <Y>
{A6L} DON'T KNOW <Y>

{A7} Where do you obtain contraception services? #
1 SVP
2 SVA
3 SUB
4 CRH
5 CRP
6 WOMEN POLYCLINIC
7 MATERNITY HOUSES
8 PHARMACY
9 DON'T KNOW

{A8} Has a health provider discussed the issue of contraception with you? <Y>

{A9} <Y> Did the health provider explain about the different options, advantages and disadvantages?

{A10} Who decided which method to use? #

1 HEALTH PROVIDER
2 ME
3 HUSBAND
4 ME AND HUSBAND

11 Which contraception methods are you familiar with?
{A11A} INJECTIONS <Y>
{A11B} PILL <Y>
{A11C} BARRIER METHOD (DIAPHRAGM, CONDOM, FOAM/GEL) <Y>
{A11D} IUD <Y>
{A11E} TUBAL LIGATION <Y>
{A11F} VASECTOMY <Y>
{A11G} LACTATIONAL AMENORRHEA (EXCLUSIVE BF) <Y>
{A11H} WITHDRAWAL <Y>
{A11I} CALENDAR METHOD <Y>
{A11J} EMERGENCY CONTRACEPTION <Y>
{A11K} ABSTAINANCE <Y>

{A12} Do you want to have another child? <Y>

{A13} When do you want to have your next child? #
1 WITHIN 1 YEAR
2 WITHIN 2 YEARS
3 MORE THAN 2 YEARS FROM NOW
4 UNSURE WHEN

{A14} <Y> Are you currently doing something or using any method to delay or avoid getting pregnant?

{A15} <Y> Do you think that if a woman breastfeeds her baby exclusively during the first 6 months she would not need to use any method of contraception?
{A15A} <Y> Do you know the 3 rules you must follow (must state the 3 rules)?

STD

{A16} <Y> Did you receive an explaination about STD from your health provider?

17 Which diseases are you familiar with?
{A17A} AIDS <Y>
{A17B} SYPHILIS <Y>
{A17C} GONORRHEA <Y>
{A17D} TRICHOMONIASIS <Y>
{A17E} CLAMIDIYAS <Y>
{A17F} OTHER <A >

18 Do you know how to protect yourself from STD?
{A18A} CONDOM <Y>
{A18B} ABSTAINANCE <Y>
{A18C} HAVE ONLY ONE PARTNER <Y>

REPRODUCTIVE HEALTH QUESTIONNAIRE FOR HEALTH PROVIDERS
MIDTERM EVALUATION APRIL 2002
PROJECT HOPE/CS/NAVOI

{Monit}oring {Dat}e <dd/mm/yy> {Rec}ord {Num}ber <idnum>

IDENTIFICATION

{A1} Type of health facility #
1 CRH 2 CRP 3 SUB 4 SVP 5 SVA 6 City HF

{A2} Location of facility #
1 NAVOI RAYON
2 KIZILTEPA RAYON
3 NAVOI CITY

{A3} Code of facility ##

{A4} Type of health provider #
1 MEDICAL DOCTOR
2 MIDWIFE
3 NURSE

{A5A} Last Name <A > {A5B} First Name <A >

{A6} Training date <dd/mm/yy>

LACTATIONAL AMENORREHA

{A7} If practiced in the correct way, what is the method's effectiveness? #
1 Up to 50%
2 50-97%
3 98%

{A8} Is this method approved by any religion? <Y>

{A9} What are the 3 criteria for LAM (must state the 3)? <Y>

COC PILL

{A10} # If a woman wants, for how many years can she use the pills continuously?
1 Up to 5 years
2 6-10 years
3 11-15 years
4 Until menopause

{A11} <Y> Other than contraception, what are the additional benefits of using the pill (must give at least 4)?

{A12} # If used correctly, what is the method's effectiveness?
1 Up to 80%
2 81-98%
3 99%

{A13} <Y> A woman has a prolonged menstruation, though suffers from no health problems, and is interested in taking the pill.
What would you advise?

{A14} <Y> A smoking 37 year old would like to take the pill.
What would you advise?

INJECTION

{A15} <Y> Is it possible for a breastfeeding mother to receive injections?

{A16} <Y> If a woman missed her injection date by a month what should she do?

{A17} <Y> Can adolescents use the injection method?

{A18} # What is this method's effectiveness?
1 Up to 80%
2 80-98%
3 99%

PROGESTERONE ONLY PILLS

{A19} # The pill must be taken no later than ??? after the daily defined time.
1 2-3 hours
2 4-5 hours
3 6-7 hours

{A20} <Y> A breastfeeding woman with a 8 week old baby with a restored menstruation requests progesterone pills.
What would you advise?

{A21} <Y> A woman taking the progesterone pill is worried that it will interfere with her menstruation. What would you say?

STERILIZATION

{A22} <Y> A 28 year old with 2 children would like to have an operation. She also suffers from acute uterus inflammation.
What would you advise?

{A23} <Y> 36 hours ago a woman gave birth and is now requesting an operation. What would you recommend?

STI

{A24} <Y> What diseases are you familiar with? (list at least 7)

{A25} <Y> Which diseases affect not only the reproductive organs but the whole body as well? (HIV and SYPHILIS)

{A26} <Y> Please explain the ways in which AIDS can be transmitted

{A27} <Y> Can STI cause infertility?

{A28} <Y> What is the most important piece of advise you can provide your patient regarding protection from STI?

BARRIER METHOD

{A29} <Y> How long are spermicides (cream/gel/sponge/vaginal pills) effective for in each usage?

{A30} # If used correctly, what is effectiveness of the condom?
1 88%
2 80-87%
3 Less than 80%

CALENDAR METHOD

{A31} <Y> A woman with a normal menstrual cycle doesn't have a steady partner but is using the calendar method. What would you advise?

{A32} <Y> A married woman would like to use the calendar method but she does not have a normal menstrual cycle. What would you advise?

EMERGENCY METHODS

{A33} <Y> A teenager had casual intercourse 72 hours ago. What would you advise her to do?

{A34} <Y> A teenager had casual intercourse 6 days ago. What would you advise her to do?

IUD

{A35} <Y> A woman delivered 6 days ago would like to use IUD. What would you advise?

{A36} <Y> A single 38 year old women would like to use IUD. What would you advise?

IMCI QUESTIONNAIRE FOR CARETAKERS
MIDTERM EVALUATION APRIL 2002
PROJECT HOPE/CS/NAVOI

{Monit}oring {Dat}e <dd/mm/yy> Record Number <idnum>

IDENTIFICATION

{A1} Region #
1 NAVOI RAYON
2 KIZILTEPA RAYON
3 NAVOI CITY

{A2} In which type of health facility do you normally receive treatment? #
1 CRH 2 CR Child Poly 3 SUB 4 SVP 5 SVA 6 City HF

{A3} Code of health facility #

{A4} Type of caretaker #
1 MOTHER
2 FATHER
3 GRANDMOTHER
4 GRANDFATHER
5 MOTHER-IN-LAW
6 FATHER-IN-LAW
7 OTHER

5 Name of health provider:
{A5A} Last Name <A >
{A5B} First Name <A >

INFORMATION OF CHILD

{A6} Date of birth <dd/mm/yy>

CHILDHOOD ILLNESS

7 What is the reason for your visit at the health provider today?
{A7A} DIARREHA <Y>
{A7B} BLOOD IN STOOL <Y>
{A7C} COUGH <Y>
{A7D} DIFFICULT/FAST BREATHING <Y>
{A7E} FEVER <Y>
{A7F} CONVULSIONS <Y>
{A7G} EAR PROBLEMS <Y>
{A7H} PAIN IN THE THROAT <Y>
{A7I} PRE SCHEDULED APPOINTMENT / HEALTH DAY <Y>

{A8} How long has your child been sick? #
1 ONE DAY (OR SAME DAY)
2 TWO DAYS
3 THREE DAYS OR MORE

9 What medication did the health provider perscribe/give to the child?
{A9A} ANTIBIOTICS <Y>
{A9B} OTHER ORAL MEDICINE <Y>
{A9C} ORS <Y>
{A9D} OTHER <A >
{A9E} NO MEDICINE <Y>

10 Could you tell me how and when you will give the medication?
{A10} KNOWLEDGE OF CORRECT DOSAGE AND FREQUENCY FOR EACH MEDICINE <Y>

NUTRITION

{A11} Did the provider ask about your child's nutrition? <Y>

{A12} <Y> Did the health provider explain about proper child nutrition (not necessarily when sick)?

{A13} Do you know what affect tea has on iron absorbtion? #
1 GOOD
2 BAD
3 NO EFFECT
4 DON'T KNOW

DIARRHEA

{A14} # When the child has diarrhea, do you breastfeed him/her less than usual, about the same amount, or more than usual?
1 LESS
2 SAME
3 MORE
4 CHILD NOT BREASTFEED
5 DON'T KNOW

{A15} # When the child has diarrhea, do you offer him/her less than usual to drink, about the same amount, or more than usual to drink?
1 LESS
2 SAME
3 MORE
4 NOTHING TO DRINK
5 DON'T KNOW

{A16} # Do you offer less than usual to eat, about the same amount, or more than usual to eat?
1 LESS
2 SAME
3 MORE
4 NOTHING TO EAT
5 DON'T KNOW

HEALTH EDUCATION

17 Do you know the danger signs when you must return immediately to the health facility?

{A17A} DON'T KNOW / WRONG ANSWER <Y>
{A17B} SICKNESS IS GETTING WORSE <Y>
{A17C} NOT BREASTFEEDING OR DRINKING <Y>
{A17D} BLOOD IN STOOL <Y>
{A17E} HIGH FEVER / FEVER IS NOT GOING DOWN <Y>
{A17F} FAST OR DIFFICULT BREATHING <Y>

QUALITY OF SERVICE

{A18} How long did the appointment last? #

1 LESS THAN 10 MINUTES
2 BETWEEN 10-20 MINUTES
3 MORE THAN 20 MINUTES

{A19} Did you receive a date for the next visit? <Y>

IMCI QUESTIONNAIRE FOR HEALTH PROVIDERS
MIDTERM EVALUATION APRIL 2002
PROJECT HOPE/CS/NAVOI

{Monit}oring {Dat}e <dd/mm/yy> {Rec}ord {Num}ber <idnum>

IDENTIFICATION

{A1} Type of health facility #
1 CRH 2 CR Child Poly 3 SUB 4 SVP 5 SVA 6 City HF

{A2} Location #
1 NAVOI RAYON
2 KIZILTEPA RAYON
3 NAVOI CITY

{A3} Code of health facility ##

4 Name of health provider:
{A4A} Family Name <A >
{A4B} First Name <A >

INFORMATION OF CHILD

{A5} Date of birth <dd/mm/yy>

OBSERVATION CHECKLIST

6 Danger signs assessment:
{A6A} Not drinking <Y>
{A6B} Vomits everything <Y>
{A6C} Convulsions <Y>
{A6D} Lethargic or difficult to wake <Y>

7 Followed module classification guidelines:
{A7A} Cough and/or difficulties/fast breathing <Y>
{A7B} Diarrhea <Y>
{A7C} High fever <Y>
{A7D} Pain/trouble swallowing <Y>
{A7E} Ear problems <Y>
{A7F} Malnourished and/or anemic <Y>
{A7G} Vaccination status <Y>
{A7H} Weight assessment according to chart <Y>
{A7I} Other <Y>
{A7J} Please specify: <A >

MEDICATION

8 Antibiotics:
{A8A} Should the child receive antibiotics? <Y>
{A8B} Did the provider perscribe antibiotics? <Y>
{A8C} <Y> Did the provider give the first dosage of antibiotics before hospitalization?

{A9} Did the provider give oral medication and ORS? <Y>

CONSULTATION

10 Nutrition:
{A10A} Did the health provider ask what the caretaker feeds the child <Y>
{A10B} Did the health provider assess the child's nutritional status? <Y>
{A10C} <Y> Did the provider provide consultation to the caretaker regarding the child's nutrition?

11 Did the provider discuss the child's sickness and provide important and correct guidelines and consutation for treatment at home?
{A11A} Explaination of sickness <Y>
{A11B} Fluids <Y>
{A11C} Food <Y>
{A11D} Medication <Y>
{A11E} Danger signs <Y>
{A11F} When to return to the health facility IMMEDIATELY <Y>
{A11G} Scheduled follow up visit <Y>

{A12} Completed individual medical card? <Y>

{A13} Duration of appointment #
1 Less than 10 minutes
2 10-20 minutes
3 More than 20 minutes

IMCI HEALTH FACILITY QUESTIONNAIRE
MIDTERM EVALUATION APRIL 2002
PROJECT HOPE/CS/NAVOI

{Monit}oring {Dat}e <dd/mm/yy> {Rec}ord {Num}ber <idnum>

IDENTIFICATION

{A1} Type of health facility #
1 CRH 2 CR CHILD POLY 3 SUB 4 SVP 5 SVA 6 City HF

{A2} Location #
1 NAVOI RAYON
2 KIZILTEPA RAYON
3 NAVOI CITY

{A3} Code of health facility ##

OBSERVATION CHECK LIST

{A4} Have functional weighing scale <Y>

{A5} Have functional timer <Y>

{A6} Have IMCI Protocol folder <Y>

{A7} Have IMCI Record form <Y>

{A8} Have reminder materials <Y>

{A9} Have separate corner for oral rehydration treatment <Y>

{A10} Have working refrigerator <Y>

11 Required vaccinations:
{A11A} TB (BCG) <Y>
{A11B} DPT <Y>
{A11C} HEPATITIS B <Y>
{A11D} FLU <Y>
{A11E} OPV <Y>
{A11F} MEASELS <Y>
{A11G} MUMPS <Y>

12 IMCI drugs:
{A12A} ORS <Y>
{A12B} AMOXICILIN <Y>
{A12C} PENICILLIN <Y>
{A12D} ERITROMICINI <Y>
{A12E} GENTAMICIN <Y>
{A12F} PARACETAMOL <Y>
{A12G} TETRACIKLYN EYE OINTMENT <Y>
{A12H} GENCIONVIOLET <Y>
{A12I} VITAMIN A <Y>
{A12J} IRON SUPPLEMENTS <Y>
{A12K} BICILLYN 1 <Y>
{A12L} CHLOROMFINICOL <Y>
{A12M} NOSE-GASTRALPROBE <Y>
{A12N} STERILE SYRINGE <Y>
{A12O} GAUZE PAD <Y>
{A12P} IV KIT <Y>
{A12Q} IV SOLUTIONS FOR ACCUTE DEHYDRATION <Y>

Notes on Questionnaire Questions

Reproductive health for health providers
As the decision was made not to observe the health providers (due to lack of time and no formal protocol procedure such as in IMCI) the purpose of the questionnaire was to give an indication regarding the providers knowledge. The actual practice would be implied by the women's survey.
Question A21 was not included due to its confusing wording.

IMCI for health providers
Questions A7A-E are simply for general knowledge and did not serve as an indicator.
Question A9 was not included due to complications with the surveyors.
The wording in question A12 should be "Did the health provider fully complete the individual medical card?"

IMCI for caretakers
Questions A9A-E were not included due to complications with the surveyors.
Questions A14-A16 use the wording "would you" rather than "do".
Question A17A was calculated manually due to its confusing wording.